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MORBIDITY AND MORTALITY WEEKLY REPORT

Effectiveness in Disease and Injury Prevention

Public Health Focus: Effectiveness of Disease and Injury Prevention

Public health practice is based on scientifically sound strategies for improving the quality of life and reducing morbidity and premature mortality. To maximize the health benefits of available resources, public health decision-makers require information on the effectiveness, as well as the economic and social impact, of disease and injury prevention strategies (*1*). This report introduces a monthly series of articles to be published in *MMWR* (weekly) that highlight prevention effectiveness.

The development of prevention technology begins with researchers in the basic public health and biomedical sciences identifying potentially effective technologies that can be used to reduce unnecessary morbidity and premature mortality. Applied research under carefully controlled conditions may then determine whether such techniques are efficacious (e.g., the effect of smoking cessation on lung cancer). As these techniques are applied at the community level, their impact and cost can be assessed first in demonstration settings and then in routine community settings, and improvements in techniques can then be incorporated into prevention strategies.

Important considerations in the assessment of disease and injury prevention strategies (i.e., the scientific method for evaluating the effectiveness of prevention strategies) include

- identification of efficacious and effective strategies to reduce morbidity and premature mortality and improve the quality of life;
- characterization of the social, legal, and ethical impact of these strategies;
- estimation of the economic impact of prevention strategies;
- determination of optimal methods for implementing those strategies; and
- evaluation of the health impact of prevention programs.

Each report in the monthly series will highlight the knowledge base regarding a specific prevention strategy and will address related considerations, including efficacy, effectiveness, safety, and economic factors. Topics have been selected based on their inclusion in the national health objectives for the year 2000 (*2*), CDC and other

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public health program efforts, and the availability of data. In particular, the reports will present specific examples of disease and injury prevention strategies and illustrate approaches to evaluating the effectiveness of such strategies.

Reported by: Office of Program Planning and Evaluation, Office of the Director; Office of the Director, Epidemiology Program Office, CDC.

Editorial Note: Public health officials and policy makers at all levels require a scientific framework for assessing the effectiveness of disease and injury prevention as a basis for establishing priorities, selecting prevention strategies, and allocating resources. The success of prevention activities can be defined by whether they delay or avert morbidity and mortality. However, the ability to evaluate objectively many prevention techniques with randomized controlled trials is often limited by fiscal, ethical, or other constraints. The *MMWR Recommendations and Reports* issue, "A Framework for Assessing the Effectiveness of Disease and Injury Prevention" (*1*), focuses on the challenges of assessment that arise as a consequence of these constraints. Reports in the *MMWR* (weekly) series will describe examples of how prevention effectiveness can be assessed.

Because public health programs sometimes may begin to implement preventive measures before appropriate assessments are completed, gaps may exist in knowledge of the efficacy, effectiveness, safety, or economic impact of specific prevention strategies. The series of reports in *MMWR* (weekly) will characterize many of these gaps and describe how they have been addressed. In addition, the reports in this series are intended to 1) provide decision-makers with information about the potential impact of these interventions on the health of their communities; 2) suggest approaches suitable for adaptation to public health practice; and 3) encourage further examination of these topics and stimulate additional systematic efforts by public health professionals to assess and enhance the effectiveness of public health programs.

References

1. CDC. A framework for assessing the effectiveness of disease and injury prevention. MMWR 1992;41(no. RR-3).
2. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC; US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.

Topics in Minority Health

Behavioral Risk Factor Survey of Chinese – California, 1989

During the 1980s, Asians/Pacific Islanders were the fastest growing racial/ethnic group in both the United States and California (*1*). In Alameda County (which includes Oakland), California, persons of Chinese origin or ancestry are the largest subgroup (35.6%) among the more than 192,000 Asians (*2*). The prevalence of health risk factors for noninfectious health concerns (e.g., heart disease, cancer, and unintentional injuries) in Asian/Pacific Islander populations has not been well defined (*3*). To characterize risk factors for selected noninfectious diseases among persons of Chinese origin or ancestry in California, Asian Health Services (a private,

Chinese — Continued

nonprofit community health center) and the California Department of Health Services adapted CDC's Behavioral Risk Factor Surveillance System (BRFSS) for use in the Chinese community in Oakland. This report presents data from that survey conducted during June 1989–February 1990.

The standard BRFSS questionnaire was modified for cultural appropriateness, translated into Cantonese, backtranslated, and pretested. The 81 questions encompassed sociodemographics, acculturation, nutrition, exercise, tobacco use, alcohol consumption, hypertension, cholesterol, safety-belt use, cancer screening, and periodic examinations. A systematic sampling method targeted every second Chinese household within two census tracts with the highest concentrations of Chinese residents. Adult (aged ≥18 years) respondents were randomly selected after enumeration of household members. Chinese community health workers fluent in Cantonese underwent intensive interviewer training; from June 1989 through February 1990, they conducted person-to-person interviews with 296 (82%) of the 359 eligible Chinese residents.

The chi-square test was used to compare associations involving education, income, English fluency, and health insurance status with specific health-care behaviors and knowledge.

The mean age of the respondents was 53.3 years (standard deviation: 19.8 years); 57% were women. Most (93%) of the respondents were born in Asian countries (including Hong Kong, the People's Republic of China, Taiwan, and Vietnam); respondents had lived in the United States a mean of 11.1 years. More than half (53%) lived in households with annual incomes of less than $10,000. Most (87%) spoke little or no English, and 52% had the equivalent of an eighth-grade education or less. More than one third (35%) of all respondents had no health insurance, and almost two thirds (65%) of those aged 45–64 years were uninsured.

Persons of Chinese descent born in the United States were more likely than Chinese born elsewhere to have annual incomes of more than $10,000 (56% [95% CI = 50%–62%] versus 6% [95% CI = –5%–17%]). In addition, persons of Chinese descent born in the United States were more likely to have at least a ninth-grade education (55% [95% CI = 49%–61%] versus 10% [95% CI = –3%–23%]). Chinese who were born elsewhere were less likely to be fluent in English (7% [95% CI = 4%–9%]) than U.S.-born Chinese (90% [95% CI = 77%–103%]).

The prevalence of several risk factors was higher for Chinese than for the total California population (Table 1). These included smoking among men, never having had a blood pressure measurement, hypertension, never having had breast and cervical cancer screening tests, and hypercholesteremia. In comparison, the prevalence for use of alcohol was lower among Chinese than among the total California population.

The likelihood of ever having had a mammogram among Chinese women who had an eighth-grade education or less (25%; 95% confidence interval [CI] = 15%–35%) was lower than that among Chinese women who had a higher education level (50% [95% CI = 32%–69%]) and was lower for Chinese women who did not speak English fluently (28% [95% CI = 19%–37%] versus 100% [95% CI = 100%–100%]). Chinese men who were uninsured were less likely to have had a periodic examination in the 2 years preceding the survey (40% [95% CI = 26%–55%] versus 70% [95% CI = 60%–80%]). Chinese aged ≥40 years were less likely to have had their blood pressure measured if they were uninsured (83% [95% CI = 69%–97%] versus 95% [95% CI = 90%–100%]).

TABLE 1. Risk-factor prevalence estimates for Chinese in California and Behavioral Risk Factor Surveillance System (BRFSS), 1990*

Risk factor	Chinese in California				
	Men			Wome	
	No. surveyed	%	(95% CI†)	No. surveyed	%
Blood pressure never measured§	128	22	(15–29)	168	10
Self-reported hypertension¶	99	32	(23–42)	152	22
Cholesterol never measured	119	71	(62–79)	152	69
Hypercholesterolemia**	34	41	(25–58)	47	38
Current smoker	128	28	(20–36)	168	1
Former smoker	128	30	(22–38)	168	5
Never smoker	128	42	(34–51)	168	93
Current drinker††	128	41	(32–49)	168	14
Never had routine checkup§§	128	30	(22–38)	167	25
Never had Papanicolaou smear¶¶	–	–	–	157	45
Never had mammogram***	–	–	–	100	68
Never did breast self-exam***	–	–	–	106	75
Safety-belt nonuse†††	124	17	(10–24)	155	23

*Source for all variables: California BRFSS, 1990. Prevalence estimates and co
of 1253 men and 1448 women and are weighted to the 1986 California popula
†Confidence interval.
§Not on CDC BRFSS for California.
¶Patients had been told by a health-care professional that they had high blood
**Patients had had their cholesterol checked and had been told by a health-care p
††Had ≥1 drink during the 30 days preceding the survey.
§§Routine checkup = visiting a physician.
¶¶Women aged ≥18 years.
***Women aged ≥40 years.
†††Sometimes, seldom, or never wore safety belts.

Chinese — Continued

and for the total California population — California

Women			Total California population			
			Men		Women	
d	%	(95% CI)	%	(95% CI)	%	(95% CI)
10	(5–14)		–	–	–	–
22	(15–28)		15	(12–17)	17	(15–19)
69	(62–76)		42	(39–45)	35	(32–38)
38	(24–52)		16	(14–19)	18	(16–20)
1	(0– 3)		21	(19–24)	18	(16–21)
5	(2– 9)		34	(31–37)	22	(19–24)
93	(90–97)		44	(41–47)	60	(57–62)
14	(9–20)		69	(66–72)	51	(48–54)
25	(19–32)		5	(4– 7)	4	(3– 5)
45	(37–53)		–	–	5	(4– 7)
68	(59–77)		–	–	51	(48–53)
75	(66–83)		–	–	9	(7–11)
23	(16–30)		16	(14–19)	9	(8–11)

d confidence intervals for California are based on a sample population.

blood pressure.

care professional that their blood cholesterol level was high.

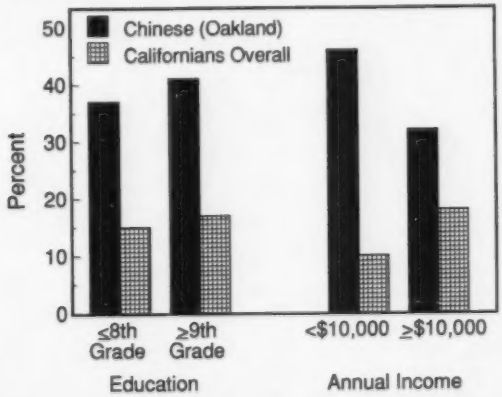
Chinese – Continued

Respondents were less likely to correctly identify the association between sodium intake and hypertension if they were from low-income households (34% [95% CI = 26%–42%] versus 46% [95% CI = 37%–54%]) or if they were not fluent in English (37% [95% CI = 31%–43%] versus 68% [95% CI = 53%–83%]). Respondents were also less likely to correctly identify the association between cholesterol and heart disease if they lived in households with annual incomes less than $10,000 (30% [95% CI = 22%–37%] versus 70% [95% CI = 62%–78%]) or if they had an eighth-grade education or less (30% [95% CI = 23%–37%] versus 68% [95% CI = 60%–75%]). Self-reported hypercholesterolemia was more prevalent among Chinese than among the total population of California, regardless of education or income levels (Figure 1).

Reported by: A Chen, MD, R Lew, MPH, V Thai, KL Ko, MS, L Okahara, S Hirota, S Chan, MD, WF Wong, MD, Asian Health Svcs, Oakland; G Saika, MS, Univ of California, San Francisco; LF Folkers, MPH, B Marquez, MPH, Health Promotion Section, California Dept of Health Svcs. Div of Chronic Disease Control and Community Intervention, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report document that the health profiles of persons of Chinese origin or ancestry in California differ from those of the total population of California and are consistent with other surveys indicating that some risk factors are higher in certain subgroups of Asians/Pacific Islanders (*4*). For example, the 1987 National Health Interview Survey found that the prevalence of smoking was 20% for all male Asians/Pacific Islanders (L. Harlan, National Cancer Institute, National Institutes of Health, unpublished data, 1991); in comparison, the prevalence of smoking was 28% among Chinese men in this survey and 35% in a recent survey involving Vietnamese men (*5*).

FIGURE 1. Self-reported prevalence of hypercholesterolemia among 81 Chinese in Oakland, California, and among the total California population, by education level and income* – California Behavioral Risk Factor Surveillance System, 1990



*For percentages for Chinese—for education and for income ≥$10,000, 95% confidence interval (CI) = ±11% for income <$10,000, 95% CI = ±12%. For percentages for Californians—for education ≤8th grade, 95% CI = ±6%; for education ≥9th grade and income ≥$10,000, 95% CI = ±2%; and for income <$10,000, 95% CI = ±4%.

Chinese — Continued

Differences in the ethnicity of the interviewer and the respondent can influence responses to some sensitive questions (*6*); accordingly, this survey used a community-sensitive research approach (*7*) based on the theory of community participation (*8*) to recruit community residents as interviewers and to form a broad community health coalition to promote and guide data collection and use. In April 1990, the California Commission for Economic Development sponsored a public hearing that publicized the survey findings. Subsequently, Asian Health Services developed two health-promotion programs to address the high prevalence of smoking and hypertension.

This survey has at least three limitations. First, because the sample size was relatively small, and the geographic distribution of Chinese living in Oakland was highly focal, the findings may not be representative of Chinese living elsewhere. Second, all survey responses were self-reported but were not independently validated, and survey reliability was not assessed. Third, events in China during June 1989 (within the survey period) deterred some eligible residents in Oakland from participating in this survey. Consequently, the data-collection period was extended, increasing costs for the survey.

Differences reported in this survey underscore the need for tailored data collection approaches—such as characterizing ethnicity, nativity, income, insurance status, and language fluency—to accurately determine the health status of Asians/Pacific Islanders and other racial/ethnic groups. Because the indicators of education and income are frequently associated with health risk, health knowledge, and access to care, identification of high-risk subgroups is critical in planning health-promotion and disease-prevention strategies that address the nation's year 2000 health objectives (*9*).

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Epidemiologic Notes and Reports

Deaths Associated with Infant Carriers — United States, 1986–1991

In the United States, injuries are the leading cause of death and disability among children aged 1–4 years and the sixth leading cause of death and disability among infants aged <1 year (*1–4*). Small children and infants can be injured when left unattended, even in environments that appear safe. Often such injuries and deaths are associated with use of consumer products, including products designed for children aged <1 year (i.e., strollers, walkers, car seats, and infant carriers [ICs]). From January 1986 through October 1991, the U.S. Consumer Product Safety Commission (CPSC) received reports of 26 fatalities associated with IC-related injuries. To inform public health and health-care providers about potential risks associated with use of ICs, CDC summarized epidemiologic information and related details regarding these incidents.

CPSC receives or identifies injury-related reports on consumer products—including reports of IC-related deaths—from a variety of sources such as consumers, attorneys, private health-care providers, death certificates, and newspaper articles and through the Medical Examiner/Coroners Alert Project (MECAP). For this study, an IC was defined as a product that is intended to carry and/or transport an infant or child and that does not mount on a bicycle or is not worn by an adult. Car seats used as ICs and ICs improperly used as car seats were included. Car-seat–related deaths caused by motor-vehicle crashes were excluded.

Deaths occurred in 16 states. Six deaths occurred in 1989 and in 1990, five in 1987 and in 1991, two in 1988, and one in 1986; in one case, date of death was unknown. Of the 26 decedents, 13 were female, 11 were male, and sex was unknown for two. Twenty-one deaths occurred among children aged <1 year; the median age at death was 7 months (range: 2–66 months). Causes of death were asphyxiation (18 deaths), blunt trauma (five), and burns (three).

Of the 18 deaths resulting from asphyxiation, nine occurred because the infant or child had become entangled in or hanged by the restraining straps on the IC. For example: 1) an IC placed on a dining room chair overturned, and the unattended 4-month-old infant hanged by the neck from a safety shoulder strap on the IC; and 2) a 10-month-old infant died when the restraint strap of a car seat, being used as an IC in the home, became wrapped around the child's neck.

Of the nine remaining asphyxiation cases, five involved ICs that overturned after being placed on an adult's bed or waterbed, causing the infant/child to suffocate in the pillows or linens on the bed. In three instances, asphyxiation occurred when the infant turned around in the carrier/seat and suffocated in the padding or seat covers of the IC.

Of five blunt-trauma–associated deaths, three were caused by falls. For example, a grocery cart containing an IC in which the infant was riding overturned, throwing the infant to the ground.

The remaining blunt-trauma–associated and burn-associated deaths involved motor vehicles. For example, an IC improperly used as a car seat failed to restrain the child. The three deaths by burns occurred among infants restrained in ICs who were left unattended in cars with siblings who started fires inside the cars, then

Infant Carriers — Continued

escaped, leaving the restrained infant in the car. In two of the three cases, rescue workers reported having difficulty extracting the child from the IC.

Reported by: Consumer Product Safety Commission, Washington, DC. Surveillance and Programs Br, Div of Environmental Hazards and Health Effects; Div of Injury Control, National Center for Environmental Health and Injury Control, CDC.

Editorial Note: Although commercial baby products are designed to improve the convenience and safety of child mobility, all products have some risk associated with their use. The value of car seats and the number of lives saved through their use is well established (*5–7*); in comparison, the benefits and risks of ICs have not been well characterized.

Public health and health-care providers should emphasize to parents and other persons who provide care to young children the following considerations regarding use of ICs and car seats in the home and car. First, beds, especially waterbeds, do not provide a stable surface for ICs or car seats. Second, only car seats approved for use in an automobile should be used in the car to restrain children. Third, children and infants should never be left unattended, even when they appear safely strapped in a carrier/seat. Fourth, straps and restraining buckles on ICs and car seats should be fastened for each use; in addition, they should be adjusted to fit comfortably, and to prevent the infant from turning in the seat. Cross-straps should be placed low enough to avoid the infant's neck, even if the infant slips down in the carrier/seat. Fifth, manufacturers' recommendations and instructions should be read and carefully followed (*8*).

Problems, complaints, and/or defects related to products that could result in injury should be reported to the CPSC Hotline, telephone (800) 638-2772. Deaths associated with consumer products should be reported to MECAP, telephone (800) 638-8095.

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Notices to Readers

1992 Diabetes Translation Conference

CDC will sponsor the 1992 Diabetes Translation Conference, May 26–29, 1992, in Atlanta. The theme is "Public Health Approaches to Diabetes: Turning Obstacles into Opportunities." Representatives from state chronic disease programs, health-related federal agencies, health programs in academia, and diabetes voluntary agencies will examine educational, environmental, and behavioral obstacles to diabetes care. In addition, participants will further refine effective strategies at the individual, community, and national levels for translating diabetes knowledge and state-of-the-art technology into public health practice.

Registration material and additional information are available from the Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC, Mailstop K-10, 1600 Clifton Road, NE, Atlanta, GA 30333; telephone (404) 488-5015 or FTS (404) 488-5015; fax (404) 488-5966.

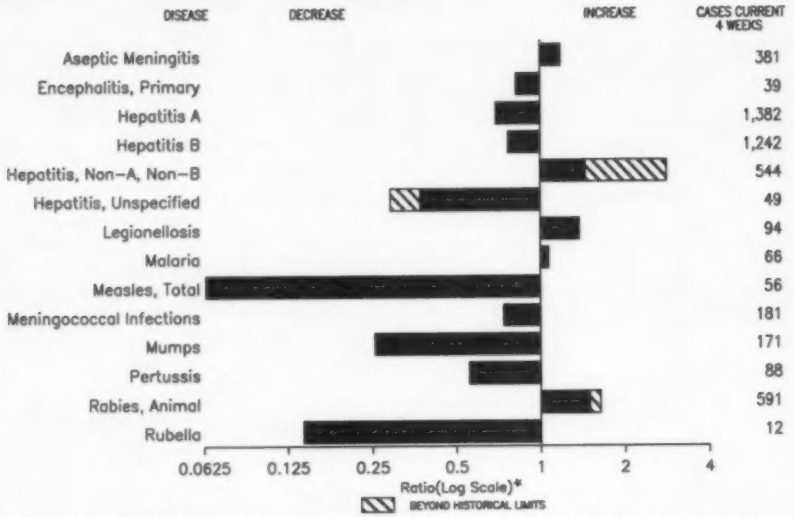
Symposium on Quantitative Methods for Utilization of Multi-Source Data in Public Health

CDC and the Agency for Toxic Substances and Disease Registry will cosponsor the Symposium on Quantitative Methods for Utilization of Multi-Source Data in Public Health, January 26–27, 1993, in Atlanta. A short course in meta-analysis will be offered January 25, 1993, in conjunction with the symposium. The symposium and course are open to the public.

Abstracts related to the following areas will be considered for presentation: identification, verification, and linkage of datasets; design of multi-source data studies; data analytic issues; meta-analysis, modeling, and other data analytic techniques; mapping and other graphical techniques; and use of surveillance data for comprehensive decisions in state and local health agencies. Abstracts should be postmarked no later than June 15, 1992.

Registration and abstract information is available from the Division of Surveillance and Epidemiology, Epidemiology Program Office, CDC, Mailstop C-08, 1600 Clifton Road, NE, Atlanta, Georgia 30333; telephone (404) 639-0080.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending April 18, 1992, with historical data — United States



*Ratio of current 4-week total to the mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending April 18, 1992 (16th Week)

	Cum. 1992		Cum. 1992
AIDS	14,587	Measles: imported	49
Anthrax	-	indigenous	439
Botulism: Foodborne	7	Plague	-
Infant	18	Poliomyelitis, Paralytic*	-
Other	-	Psittacosis	15
Brucellosis	4	Rabies, human	-
Cholera	20	Syphilis, primary & secondary	10,630
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year	-
Diphtheria	2	Tetanus	4
Encephalitis, post-infectious	29	Toxic shock syndrome	76
Gonorrhea	147,440	Trichinosis	11
Haemophilus influenzae (invasive disease)	511	Tuberculosis	5,477
Hansen Disease	42	Tularemia	18
Leptospirosis	10	Typhoid fever	92
Lyme Disease	1,108	Typhus fever, tickborne (RMSF)	47

*Nine suspected cases of poliomyelitis have been reported in 1991; 4 of the 8 suspected cases in 1990 were confirmed, and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending April 18, 1992, and April 20, 1991 (16th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	14,587	1,400	161	29	147,440	174,207	5,493	4,530	1,336	195	396	1,108
NEW ENGLAND	517	94	13	-	3,235	4,585	212	194	22	13	32	81
Maine	18	8	-	-	33	35	27	12	3	-	2	-
N.H.	19	4	2	-	-	117	14	15	6	-	3	5
Vt.	3	3	1	-	7	16	2	3	2	-	2	1
Mass.	313	34	7	-	1,206	1,882	99	137	8	13	16	28
R.I.	37	45	3	-	262	369	47	14	3	-	9	26
Conn.	127	-	-	-	1,727	2,166	23	13	-	-	-	21
MID. ATLANTIC	3,521	177	9	4	13,764	22,311	472	633	134	11	124	832
Upstate N.Y.	445	76	-	-	2,063	3,887	130	150	80	6	52	579
N.Y. City	1,959	22	1	-	4,574	8,935	146	63	2	-	2	-
N.J.	712	4	-	-	2,219	3,342	68	172	37	-	20	78
Pa.	405	75	8	4	4,908	6,147	128	248	15	5	50	175
E.N. CENTRAL	1,368	202	48	3	23,725	33,616	626	586	65	10	85	26
Ohio	288	66	20	-	8,445	10,276	144	90	36	-	43	19
Ind.	155	16	3	-	2,689	3,369	189	157	1	3	4	4
Ill.	516	36	10	-	8,783	10,178	113	37	8	1	4	2
Mich.	340	80	14	3	2,971	7,630	47	196	5	6	24	1
Wis.	69	4	1	-	837	2,163	133	106	15	-	10	-
W.N. CENTRAL	470	87	4	4	7,621	8,636	608	249	99	5	16	35
Minn.	66	5	1	-	870	908	203	17	3	1	1	-
Iowa	27	18	-	2	575	533	18	13	1	-	3	6
Mo.	265	32	-	-	4,533	5,225	124	189	91	4	4	25
N. Dak.	1	1	-	-	25	23	21	1	-	-	1	2
S. Dak.	3	3	-	1	65	122	141	1	-	-	-	-
Nebr.	18	9	1	1	3	614	49	12	-	-	7	1
Kans.	90	19	2	-	1,550	1,211	52	16	4	-	-	1
S. ATLANTIC	3,294	322	29	10	53,531	51,516	351	790	124	27	55	58
Del.	38	10	4	-	491	692	10	73	-	1	7	23
Md.	366	45	7	-	4,844	4,977	74	127	14	6	9	5
D.C.	260	7	-	-	2,589	3,233	7	38	-	-	6	-
Va.	155	54	6	3	6,225	4,991	29	66	12	11	6	19
W. Va.	15	-	1	-	279	366	4	22	-	5	-	1
N.C.	174	40	8	-	7,107	9,734	25	129	35	-	10	5
S.C.	145	5	-	-	3,079	3,929	9	18	-	-	12	-
Ga.	462	36	1	-	16,486	13,341	39	98	37	-	-	1
Fla.	1,679	125	2	7	12,431	10,253	154	219	26	4	5	4
E.S. CENTRAL	449	65	6	-	13,959	15,437	79	346	427	1	20	11
Ky.	49	29	4	-	1,334	1,629	24	27	-	-	10	4
Tenn.	145	15	1	-	4,377	5,950	31	280	423	-	8	7
Ala.	170	14	-	-	4,647	3,737	11	37	4	1	2	-
Miss.	85	7	1	-	3,601	4,121	13	2	-	-	-	-
W.S. CENTRAL	1,384	105	13	3	14,583	18,194	465	477	20	37	4	13
Ark.	61	8	7	-	2,691	2,104	34	32	4	3	-	1
La.	266	7	-	-	1,874	3,725	26	49	-	1	-	-
Okla.	100	-	1	2	1,444	1,951	69	83	14	2	2	5
Tex.	957	90	5	1	8,574	10,414	336	313	2	31	2	7
MOUNTAIN	385	44	7	1	3,193	3,602	768	203	65	24	26	1
Mont.	2	-	1	-	25	24	25	16	10	-	2	-
Idaho	7	4	-	-	41	54	19	23	1	-	1	-
Wyo.	3	-	-	-	17	38	1	2	5	-	1	-
Colo.	132	14	3	1	1,132	975	214	41	24	16	3	-
N. Mex.	44	6	2	-	275	326	61	40	4	3	1	-
Ariz.	119	15	1	-	1,061	1,365	378	39	10	1	11	-
Utah	31	-	-	-	52	114	48	3	6	4	1	1
Nev.	47	5	-	-	590	706	22	39	5	-	6	-
PACIFIC	3,199	304	32	4	13,829	16,310	1,912	1,052	380	67	34	51
Wash.	135	-	-	-	1,191	1,419	183	82	38	2	2	1
Oreg.	88	-	-	-	442	598	127	92	20	5	-	-
Calif.	2,906	268	29	3	11,662	13,850	1,529	872	321	59	31	50
Alaska	7	2	3	-	230	225	9	3	1	1	-	-
Hawaii	53	34	-	1	304	218	64	3	-	-	1	-
Guam	-	-	-	-	35	-	4	2	-	2	-	1
P.R.	107	47	-	-	15	190	7	89	5	4	1	-
V.I.	2	-	-	-	39	200	5	3	-	-	-	-
Amer. Samoa	-	-	-	-	10	20	-	1	-	-	-	-
C.N.M.I.	-	-	-	-	24	2	-	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending April 18, 1992, and April 20, 1991 (16th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
UNITED STATES	215	10	439	1	49	3,951	777	42	874	20	354	657	5	50	342
NEW ENGLAND	10	-	3	-	5	11	48	1	1	1	35	77	-	4	1
Maine	-	-	-	-	-	-	3	-	-	-	2	3	-	-	-
N.H.	1	-	1	-	-	-	4	-	-	1	14	11	-	-	1
Vt.	-	-	-	-	-	5	1	-	-	-	-	3	-	-	-
Mass.	5	-	2	-	3	-	20	1	1	-	16	54	-	-	-
R.I.	1	-	-	-	-	-	-	-	-	-	-	-	-	4	-
Conn.	3	-	-	-	2	6	20	-	-	-	3	6	-	-	-
MID. ATLANTIC	63	2	61	-	6	2,587	79	4	60	-	49	72	2	6	224
Upstate N.Y.	9	1	1	-	1	87	36	3	29	-	18	40	2	5	215
N.Y. City	29	1	26	-	1	725	9	-	4	-	2	-	-	-	-
N.J.	16	-	33	-	1	646	14	-	7	-	8	7	-	1	-
Pa.	9	-	1	-	3	1,129	20	1	20	-	21	25	-	-	9
E.N. CENTRAL	10	-	10	-	2	55	109	6	94	1	25	143	-	5	15
Ohio	1	-	2	-	1	1	26	6	34	1	8	55	-	-	-
Ind.	2	-	8	-	-	-	6	-	4	-	8	23	-	-	1
Ill.	2	-	-	-	-	24	42	-	26	-	3	29	-	5	3
Mich.	4	-	-	-	-	25	28	-	28	-	1	20	-	-	11
Wis.	1	-	-	-	1	5	7	-	2	-	5	16	-	-	-
W.N. CENTRAL	12	-	5	-	-	17	33	2	25	-	27	56	-	2	7
Minn.	5	-	3	-	-	4	5	-	5	-	9	21	-	-	4
Iowa	2	-	-	-	-	7	3	1	5	-	1	4	-	-	2
Mo.	3	-	1	-	-	-	12	-	10	-	12	19	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	1	-	2	1	-	-	-
S. Dak.	1	-	-	-	-	-	-	-	-	-	1	1	-	-	-
Nebr.	-	-	-	-	-	-	3	1	2	-	2	4	-	-	-
Kans.	1	-	1	-	-	6	10	-	2	-	-	6	-	2	-
S. ATLANTIC	40	2	62	1	5	198	144	14	384	2	48	34	-	3	3
Del.	2	-	1	-	-	17	2	-	-	-	-	-	-	-	-
Md.	14	-	1	1†	4	63	14	1	34	-	14	6	-	-	1
D.C.	2	-	-	-	-	-	-	-	2	-	-	-	-	1	-
Va.	7	-	5	-	1	18	21	-	20	-	4	4	-	-	-
W. Va.	-	-	-	-	-	-	12	1	13	-	3	6	-	-	-
N.C.	6	-	19	-	-	1	27	-	68	-	6	7	-	-	-
S.C.	-	-	-	-	-	12	11	-	45	-	9	-	-	-	-
Ga.	2	-	-	-	-	-	19	6	24	2	4	6	-	-	-
Fla.	7	2	36	-	-	87	38	6	178	-	8	5	-	2	2
E.S. CENTRAL	4	4	187	-	17	1	56	-	26	3	7	19	-	2	-
Ky.	-	4	185	-	-	-	21	-	-	-	-	-	-	-	-
Tenn.	1	-	-	-	1	1	13	-	12	2	4	9	-	2	-
Ala.	3	-	-	-	-	-	20	-	4	1	3	10	-	-	-
Miss.	-	-	2	-	16	-	2	-	10	-	-	-	-	-	-
W.S. CENTRAL	2	-	62	-	-	5	59	10	127	-	13	14	-	-	1
Ark.	-	-	-	-	-	5	10	-	4	-	7	-	-	-	1
La.	-	-	-	-	-	-	10	3	11	-	-	7	-	-	-
Okla.	2	-	-	-	-	-	7	-	2	-	6	7	-	-	-
Tex.	-	-	62	-	-	-	32	7	110	-	-	-	-	-	-
MOUNTAIN	9	-	1	-	-	176	46	3	58	2	49	84	1	1	2
Mont.	-	-	-	-	-	-	9	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	1	6	-	1	2	13	15	1	1	-
Wyo.	-	-	1	-	-	-	2	-	-	-	-	3	-	-	-
Colo.	5	-	-	-	-	1	6	-	4	-	19	36	-	-	-
N. Mex.	2	-	-	-	-	86	3	N	N	-	11	12	-	-	1
Ariz.	2	-	-	-	-	72	10	3	37	-	-	8	-	-	-
Utah	-	-	-	-	-	6	4	-	13	-	5	10	-	-	-
Nev.	-	-	-	-	-	10	6	-	3	-	1	-	-	-	1
PACIFIC	65	2	48	-	14	901	203	2	99	11	101	158	2	27	89
Wash.	5	-	-	-	7	4	28	-	5	5	29	42	-	-	-
Oreg.	6	-	3	-	-	17	32	N	N	1	10	28	-	1	-
Calif.	49	2	37	-	6	878	133	2	91	5	58	58	2	24	88
Alaska	1	-	8	-	1	-	6	-	-	-	-	5	-	-	-
Hawaii	4	-	-	-	-	2	4	-	3	-	4	25	-	2	1
Guam	1	U	1	U	3	-	-	U	4	U	-	-	U	-	-
P.R.	-	-	5	-	-	7	3	-	-	-	8	12	-	-	-
V.I.	-	-	-	-	-	2	-	1	10	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	24	-	U	-	U	139	-	U	-	-
C.N.M.I.	-	U	-	U	-	-	-	U	-	U	1	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.
N: Not notifiable U: Unavailable †International §Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending April 18, 1992, and April 20, 1991 (16th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	10,630	12,842	76	5,477	5,961	18	92	47	2,333
NEW ENGLAND	202	353	5	103	159	-	10	2	215
Maine	-	-	-	20	16	-	-	-	-
N.H.	-	10	3	-	-	-	-	-	-
Vt.	1	1	-	-	1	-	-	-	-
Mass.	90	174	2	52	74	-	7	1	-
R.I.	13	16	-	10	16	-	-	1	-
Conn.	98	152	-	21	52	-	3	-	215
MID. ATLANTIC	1,579	2,209	11	1,242	1,340	-	31	1	748
Upstate N.Y.	109	103	4	53	101	-	5	-	438
N.Y. City	797	1,122	-	768	825	-	11	-	-
N.J.	213	364	-	210	255	-	11	-	218
Pa.	460	620	7	211	159	-	4	1	92
E.N. CENTRAL	1,266	1,444	22	525	679	-	3	5	30
Ohio	213	181	8	93	104	-	2	4	1
Ind.	74	29	2	50	45	-	-	-	-
Ill.	610	736	3	310	366	-	-	-	7
Mich.	183	341	9	49	129	-	1	-	1
Wis.	186	157	-	23	35	-	-	1	21
W.N. CENTRAL	408	219	9	105	168	3	1	1	450
Minn.	27	25	2	22	32	-	-	-	107
Iowa	11	21	3	8	24	-	-	-	53
Mo.	303	130	1	44	66	3	1	1	2
N. Dak.	1	-	1	2	4	-	-	-	24
S. Dak.	-	1	-	9	11	-	-	-	28
Nebr.	1	1	2	2	6	-	-	-	2
Kans.	65	41	-	18	25	-	-	-	234
S. ATLANTIC	3,053	3,930	9	1,133	1,061	3	9	12	466
Del.	67	47	2	5	8	-	-	-	84
Md.	237	345	1	84	96	2	1	-	156
D.C.	153	237	-	47	64	-	1	-	5
Va.	253	319	1	98	95	1	-	-	74
W. Va.	5	10	-	20	29	-	1	-	14
N.C.	727	602	2	168	114	-	-	10	2
S.C.	350	464	1	114	121	-	1	-	33
Ga.	664	958	1	233	213	-	-	-	93
Fla.	597	948	1	364	321	-	5	2	5
E.S. CENTRAL	1,554	1,340	-	286	442	5	2	-	46
Ky.	43	27	-	107	98	1	-	-	28
Tenn.	357	488	-	6	136	4	-	-	-
Ala.	727	467	-	131	110	-	-	-	18
Miss.	427	358	-	42	98	-	2	-	-
W.S. CENTRAL	1,949	2,211	1	478	589	6	1	24	187
Ark.	309	147	-	39	59	3	-	6	13
La.	787	726	-	27	31	-	-	-	-
Okla.	73	48	-	29	42	3	-	18	98
Tex.	780	1,290	1	383	457	-	1	-	76
MOUNTAIN	135	164	6	151	151	1	2	1	33
Mont.	2	1	-	-	-	-	-	-	2
Idaho	1	3	1	8	2	-	1	-	-
Wyo.	1	1	-	-	2	-	-	-	10
Colo.	19	23	2	5	6	-	1	-	-
N. Mex.	16	8	-	20	9	1	-	-	1
Ariz.	60	125	2	77	83	-	-	-	20
Utah	2	3	1	19	25	-	-	1	-
Nev.	34	-	-	22	24	-	-	-	-
PACIFIC	484	972	13	1,454	1,372	-	33	1	158
Wash.	32	51	-	81	85	-	2	-	-
Oreg.	18	27	-	33	33	-	-	-	-
Calif.	419	889	13	1,258	1,165	-	29	1	149
Alaska	2	2	-	17	25	-	-	-	9
Hawaii	13	3	-	65	64	-	2	-	-
Guam	1	-	-	11	-	-	1	-	-
P.R.	68	130	-	40	46	-	-	-	15
V.I.	19	38	-	2	1	-	-	-	-
Amer. Samoa	-	-	-	-	1	-	-	-	-
C.N.M.I.	2	-	-	8	4	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending April 18, 1992 (16th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	595	425	88	51	11	20	36
Boston, Mass.	180	112	33	21	5	9	12
Bridgeport, Conn.	39	29	3	4	1	2	2
Cambridge, Mass.	21	15	1	5	-	-	2
Fall River, Mass.	30	27	2	1	-	-	3
Hartford, Conn.	99	40	12	4	1	2	-
Lowell, Mass.	27	18	6	1	-	2	3
Lynn, Mass.	15	14	-	1	-	-	2
New Bedford, Mass.	25	21	1	2	-	1	-
New Haven, Conn.	41	30	5	3	2	1	1
Providence, R.I.	34	25	5	4	-	-	-
Somerville, Mass.	5	2	2	1	-	-	-
Springfield, Mass.	38	28	7	1	1	1	5
Waterbury, Conn.	32	21	8	2	-	1	1
Worcester, Mass.	49	43	3	1	1	1	5
MID. ATLANTIC	2,586	1,746	483	257	78	52	119
Albany, N.Y.	44	32	7	1	4	-	5
Allentown, Pa.	21	18	2	1	-	-	-
Buffalo, N.Y.	107	70	30	3	3	1	5
Camden, N.J.	49	30	11	3	4	1	2
Elizabeth, N.J.	23	11	4	7	1	-	-
Erie, Pa.§	65	51	11	2	1	-	3
Jersey City, N.J.	42	26	7	6	3	-	-
New York City, N.Y.	1,329	864	237	176	30	22	47
Newark, N.J.	63	36	12	11	3	1	4
Paterson, N.J.	11	8	3	-	-	-	-
Philadelphia, Pa.	395	265	67	24	18	21	26
Pittsburgh, Pa.§	57	42	10	2	2	1	1
Reading, Pa.	39	30	8	-	1	-	7
Rochester, N.Y.	138	99	19	10	7	3	9
Schenectady, N.Y.	31	30	1	-	-	-	4
Scranton, Pa.§	24	17	3	4	-	-	2
Syracuse, N.Y.	84	67	11	4	-	2	3
Trenton, N.J.	12	7	4	-	1	-	-
Utica, N.Y.	26	21	2	3	-	-	1
Yonkers, N.Y.	26	22	4	-	-	-	-
E.N. CENTRAL	1,830	1,190	327	172	81	60	105
Akron, Ohio	45	37	8	-	-	-	4
Canton, Ohio	20	14	6	-	-	-	5
Chicago, Ill.	266	103	50	57	44	12	9
Cincinnati, Ohio	140	84	36	11	6	3	11
Cleveland, Ohio	121	85	16	8	3	9	3
Columbus, Ohio	194	125	47	12	3	7	14
Dayton, Ohio	106	72	20	8	3	3	5
Detroit, Mich.	248	154	39	31	14	10	9
Evansville, Ind.	29	24	4	1	-	-	2
Fort Wayne, Ind.	48	35	9	2	1	1	2
Gary, Ind.	8	4	2	2	-	-	1
Grand Rapids, Mich.	52	42	6	3	1	-	10
Indianapolis, Ind.	170	115	29	18	4	4	12
Madison, Wis.	40	29	5	3	-	3	3
Milwaukee, Wis.	80	65	9	5	-	1	4
Peoria, Ill.	50	39	9	1	-	1	4
Rockford, Ill.	35	26	6	3	-	-	1
South Bend, Ind.	43	34	6	1	-	2	2
Toledo, Ohio	76	54	14	5	1	2	3
Youngstown, Ohio	59	49	6	1	1	2	1
W.N. CENTRAL	740	518	128	51	24	18	21
Des Moines, Iowa	67	51	13	2	1	-	3
Duluth, Minn.	22	17	4	1	-	-	-
Kansas City, Kans.	34	25	7	2	-	-	-
Kansas City, Mo.	117	81	17	8	7	4	2
Lincoln, Nebr.	31	21	9	-	-	1	-
Minneapolis, Minn.	162	106	32	17	3	4	7
Omaha, Nebr.	46	35	5	2	2	2	2
St. Louis, Mo.	155	111	19	14	8	3	3
St. Paul, Minn.	56	41	10	3	-	2	2
Wichita, Kans.	50	30	12	2	3	2	2
S. ATLANTIC	1,326	798	283	143	36	63	72
Atlanta, Ga.	196	115	37	29	7	8	2
Baltimore, Md.	119	74	25	12	4	4	10
Charlotte, N.C.	108	62	27	10	3	6	9
Jacksonville, Fla.	131	85	27	13	4	2	12
Miami, Fla.	147	73	41	23	7	3	-
Norfolk, Va.	58	38	14	3	1	2	4
Richmond, Va.	62	37	17	6	-	2	6
Savannah, Ga.	44	28	9	4	-	3	2
St. Petersburg, Fla.	75	59	8	3	5	-	1
Tampa, Fla.	140	103	24	8	1	4	19
Washington, D.C.	230	113	50	31	4	29	7
Wilmington, Del.	16	11	4	1	-	-	-
E.S. CENTRAL	759	521	141	68	14	15	70
Birmingham, Ala.	141	86	31	20	1	3	4
Chattanooga, Tenn.	41	29	10	2	-	-	4
Knoxville, Tenn.	102	68	23	7	2	2	12
Louisville, Ky.	57	41	12	3	-	1	5
Memphis, Tenn.	176	140	16	12	5	3	31
Mobile, Ala.	64	42	11	9	2	-	3
Montgomery, Ala.	45	30	7	4	2	2	2
Nashville, Tenn.	133	85	31	11	2	4	9
W.S. CENTRAL	1,330	829	277	154	44	25	71
Austin, Tex.	70	46	16	4	3	1	7
Baton Rouge, La.	62	40	15	5	2	-	-
Corpus Christi, Tex.	47	34	6	2	2	3	2
Dallas, Tex.	198	119	35	30	9	5	5
El Paso, Tex.	48	33	9	5	-	1	2
Ft. Worth, Tex.	105	57	28	12	5	3	5
Houston, Tex.	310	184	70	43	7	6	18
Little Rock, Ark.	57	41	6	7	2	1	5
New Orleans, La.	125	69	30	19	6	-	-
San Antonio, Tex.	178	117	37	17	4	3	16
Shreveport, La.	58	44	6	5	2	1	7
Tulsa, Okla.	72	45	19	5	2	1	4
MOUNTAIN	790	533	142	77	17	21	51
Albuquerque, N.M.	86	59	15	7	3	2	6
Colo. Springs, Colo.	41	29	6	6	-	-	4
Denver, Colo.	114	76	24	11	2	1	10
Las Vegas, Nev.	129	80	32	14	3	-	5
Ogden, Utah	18	14	2	2	-	-	2
Phoenix, Ariz.	183	114	29	26	5	9	12
Pueblo, Colo.	24	18	3	2	1	-	3
Salt Lake City, Utah	87	60	13	6	-	8	4
Tucson, Ariz.	108	83	18	3	3	1	5
PACIFIC	1,776	1,206	322	144	58	43	100
Berkeley, Calif.	17	11	2	2	1	1	1
Fresno, Calif.	103	70	16	9	4	4	3
Glendale, Calif.	16	12	2	-	2	-	-
Honolulu, Hawaii	60	37	13	4	2	4	3
Long Beach, Calif.	76	55	11	7	3	-	11
Los Angeles, Calif.	317	206	64	28	12	5	15
Pasadena, Calif.	41	27	6	4	-	4	2
Portland, Oreg.	117	81	23	7	4	2	5
Sacramento, Calif.	151	100	35	8	4	4	12
San Diego, Calif.	177	120	30	12	9	6	18
San Francisco, Calif.	168	90	41	28	4	4	-
San Jose, Calif.	170	127	30	8	3	2	16
Santa Cruz, Calif.	38	31	3	2	1	1	1
Seattle, Wash.	175	126	26	17	4	2	9
Spokane, Wash.	49	32	13	1	2	1	1
Tacoma, Wash.	101	81	7	7	3	3	3
TOTAL	11,732¶	7,766	2,161	1,117	383	317	645

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.
U: Unavailable

FIGURE II. Acquired immunodeficiency syndrome cases, by 4-week period of report — United States, 1984–1992

*Change in case definition.

FIGURE III. Tuberculosis cases, by 4-week period of report — United States, 1984–1992

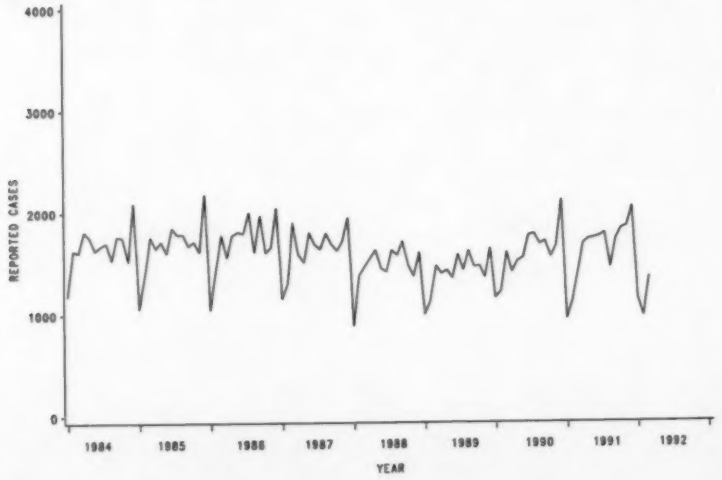
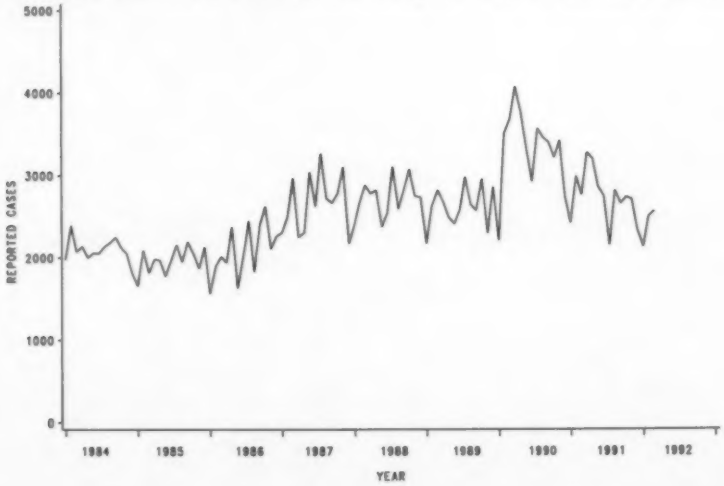


FIGURE IV. Gonorrhea cases, by 4-week period of report — United States, 1984–1992

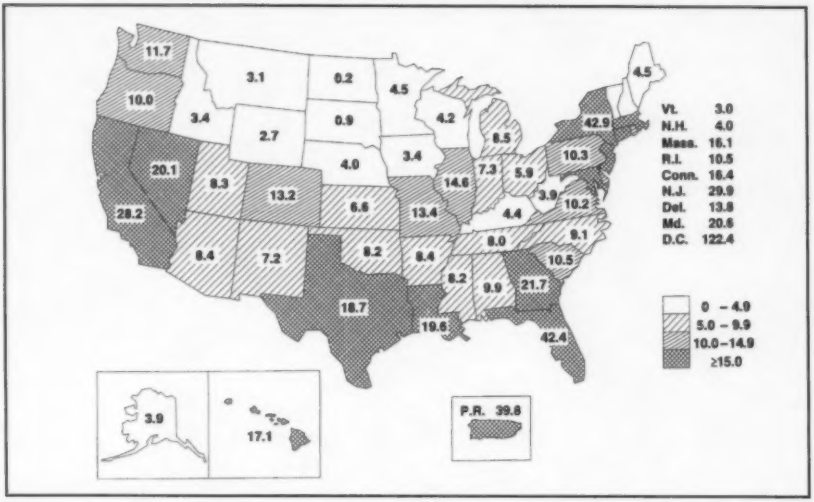
FIGURE V. Syphilis cases, by 4-week period of report — United States, 1984–1992



Quarterly AIDS Map

The following map provides information on the reported number of acquired immunodeficiency syndrome (AIDS) cases per 100,000 population by state of residence for April 1991 through March 1992. The map appears quarterly in *MMWR*. More detailed information on AIDS cases is provided in the quarterly *HIV/AIDS Surveillance Report*; single copies are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

AIDS cases per 100,000 population — United States, April 1991–March 1992



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The data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control, Atlanta, GA 30333; telephone (404) 332-4555.

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